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RESEARCH ARTICLE

People and Teams Matter in Organizational Change: Professionals' and Managers' Experiences of Changing Governance and Incentives in Primary Care

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Objectives. To explore the experiences of governance and incentives during organizational change for managers and clinical staff.

Study Setting. Three primary care settings in England in 2006–2008.

Study Design. Data collection involved three group interviews with 32 service users, individual interviews with 32 managers, and 56 frontline professionals in three sites. The Realistic Evaluation framework was used in analysis to examine the effects of new policies and their implementation.

Principal Findings. Integrating new interprofessional teams to work effectively is a slow process, especially if structures in place do not acknowledge the painful feelings involved in change and do not support staff during periods of uncertainty.

Conclusions. Eliciting multiple perspectives, often dependent on individual occupational positioning or place in new team configurations, illuminates the need to incorporate the emotional as well as technocratic and system factors when implementing change. Some suggestions are made for facilitating change in health care systems. These are discussed in the context of similar health care reform initiatives in the United States.

Key Words. Emotions, chronic illness, relationships, health care, health policy/policy analysis

In this article we discuss findings from a three-center study in England, which explored the professional experience of evolving organizational and governance structures in primary health and social care, in relation to the

management of patients with long-term physical and mental health conditions.[1] These governance structures include incentives to achieve local service reconfiguration of community teams similar to the North American "medical home" policy (Jackson et al. 2012). We argue that these rapidly changing governance systems create uncertainty for interprofessional teams. Integrating new interprofessional teams to work effectively is a slow process, especially if structures do not acknowledge the emotions involved or support staff during periods of uncertainty. The experiences that emerge from the formation of new community-based interprofessional teams, sometimes together in new physical locations but often apart, distance managers and frontline staff, and reinforce existing divisions between health and social care (Allan et al. 2005; Hall 2005; Baxter and Brumfitt 2008). We discuss the experiences of clinical staff and their managers in relation to the literature on teamwork, governance, and incentives in primary health care. We focus on the emotional reactions to the changes which were expressed by both managers and staff.

Background

Shifting the balance of care from hospital to primary and community settings in the United Kingdom has been effected through the introduction of new governance and funding arrangements and, principally, through changes to team structures and professional roles. Governance encompasses the tasks of management (decision making and control of organizations) as well as the mechanisms for the relationship between organizations, and the social and political environment in which they operate (Glasby and Peck 2006).

Policies for health and social care increasingly emphasize that professionals should work together to promote choice, independence, and self-care closer to home (Glasby and Peck 2006; Her Majesty's Government's 2007; Glasby, Martin, and Regen 2008). For social care services, most of which are provided by carers and the private sector, rather than directly by local authori-

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ties, there are imperatives to work together at several levels. These include commissioning of services and partnership working (Glasby and Peck 2006; Glasby and Dickinson 2008; Cameron 2011), but such working relies on a collective identity which can often prove elusive (Belanger and Rodriguez 2008) and may even invoke rivalry and conflict (Hall 2005; Glasby and Peck 2006; Baxter and Brumfitt 2008; Brown et al. 2011).

For partnership to work in the delivery of health and social services, West, Brodbeck, and Richter (2004) assert that interprofessional team effectiveness must be predicated on factors such as organizational commitment, leadership, clarity over objectives, and coordination of the different and distinctive professional contributions (Mackintosh 1992; Poulton and West 1999; West 2004; Cameron 2011). More needs to be done to understand these relationships (West, Brodbeck, and Richter 2004; Zwarenstein and Reeves 2006; Cameron 2011) and, in particular, how emotions shape interprofessional teams working in primary care (West and Field 1995a,b; Pescosolido 2002). Although the effect of strongly negative emotions on staff in the delivery of care within organizations has been recognized for many years (Obholzer and Zagier Roberts 1994; Stokes 1994; Taylor 2006; Smith and Cowie 2010), particularly in public sector organizations where staff face continuing organizational change (Cardona 1994; Obholzer 1994), this does not seem to be recognized by policy leaders in current service change in health and social care. Pescosolido (2002) has argued for the emergence of leaders to manage group emotions particularly in times of ambiguity, for example, during the process of strategic change in nursing organizations (Furne, Rink, and Ross 2001) and to reconcile the expectations of different groups of staff trying to meet government directives (Smith and Bryan 2005; Smith et al. 2012).

The role of emotions and relationships between people, including the human components of change (Rusaw 2009), within new governance structures is largely invisible in the policy narrative on governance and incentives (Spyridonidis and Calnan 2010; Ross et al. 2011). Therefore, for this study, we adopted Davies et al.'s (2005) definition of governance as involving organizations, teams, people, and the relationships between them which acknowledges the dynamic nature of change and the roles of people within it and has been used before (Ross et al. 2011). We defined incentives, not just as financial motivators, but as emotional support, leadership, and relationships in teams (Rusaw 2009; Spyridonidis and Calnan 2010). While our initial focus was to explore experiences of governance and incentives during organizational change for managers and clinical staff, the focus on emotional responses emerged as a significant theme from the analysis.

THE STUDY DESIGN

This was a three-center study exploring the professional experience of changing governance and incentive arrangements for the management of patients with long-term and complex conditions in health and social care. We used Realistic Evaluation (Pawson and Tilley 1997, 2004) as a framework for examining the interaction between varied mechanisms at play at an organizational level and to explore causal relationships between system change and key outcomes at a professional level. Pawson and Tilley (2004) argue that realistic evaluation is different from other evaluation methodologies as it seeks to understand how a program works to effect change. This fitted with our desire to understand the human components of system change. The research team was interprofessional and led by an experienced health services researcher. Each site team consisted of a principal investigator and a coresearcher who collected and analyzed data in each site.

Methods

The study was approved by the Local Research Ethics Committee in June 2006 and research governance approval was obtained for each site. Data were collected in 2007/2008. The sites were local organizations for primary care, primary care trusts (PCTs); two cities (A and C) and one semi-urban (B) were selected as representative of PCTs across the United Kingdom. In phase 1, service user reference groups (SURGs) were held in each site with 32 users with long-term physical conditions and nonpsychotic mental illnesses to develop vignettes highlighting critical components of care from their perspective. These were used to inform the semistructured interview schedules for managers (later in Phase 1) and frontline staff (Phase 2).

In total, 32 managers and 56 health and social care staff were interviewed, working in newly formed teams delivering frontline care to people with complex physical or mental long-term illness. The teams included social service, district nursing, and community mental health teams.[2] Clinical staff working in these teams included community matrons,[3] community nurses, occupational therapists, general practitioners, practice nurses, physiotherapists, community psychiatric nurses, social workers, and specialist nurses. Participants were selected on the basis of a purposeful sample and snowballing to ensure a diverse group of experienced professionals and support workers and

reflect professional groups working in PCTs across the United Kingdom. Interviews lasted between 30 and 70 minutes and recordings were transcribed verbatim and checked by the interviewer.

The interviews elicited views on team performance, incentives, and the experience of managing care delivery in the new governance arrangements/partnerships and organizational change.

Analysis

This involved three stages to ensure interrater reliability. First, a site-specific analysis was carried out where each coresearcher developed a list of microcodes from site data. Secondly, these microcodes were then discussed within the whole research team and amended to accommodate the data emerging across all three sites. A single, integrated coding framework, allowing the linkage of contexts, mechanisms, and subsequent outcomes (Pawson and Tilley 1997) and containing these microcodes (Atlas codes), was then developed for use across the sites. Each of the interview transcripts was coded electronically against this coding framework (Byng, Norman, and Redfern 2005) through the data handling package Atlas-ti. In the analysis we identified key outcomes such as practitioners' perceptions of their own and patients' well-being, and explored these data to look for links between the process of policy implementation (mechanisms) and the context to these key outcomes. In this way we endeavored to examine processes of change with program outcomes. We then looked for patterning to develop themes providing provisional explanations through the use of data quotes. Findings from Phase 2 were presented to each local SURG and feedback was used to add meaning to the interpretation of results. Service user feedback was included in the third stage, a cross-case analysis undertaken by two members of the research team not involved in initial data analysis.

Service users, managers, and frontline staff views of change (Ross et al. 2009) echoed the government policies of choice, self-help, and care closer to home. An example was the concern to reduce hospital admissions and lengths of stay, which was regarded positively for a number of reasons, not least of which was that it was what patients or clients themselves preferred. Indeed, staff suggested that for people with mental illness hospital admission was a disruptive experience.

> I think the outcome really is that most people prefer, if possible, to be treated at home in their own environment with their family [Manager PCT Mental Illness]

However, staff and managers described their struggle to maintain morale in existing teams and the stresses within new teams in the context of new governance and incentives arrangements. We suggest that the realignment of teams and professional roles can generate resistance and take time to be effective, especially if structures do not acknowledge the painful feelings involved in change and do not support staff during periods of uncertainty. First of all, this is because the formation of new interprofessional teams, often designed to reduce admissions and sometimes working together in new physical locations, but often geographically dispersed, involves stressful experiences for managers and frontline staff. And secondly because new teams appear to have reinforced existing divisions between health and social care (Allan et al. 2005; Hall 2005; Goddard and Mannion 2006; Baxter and Brumfitt 2008). We present data from the managers' and frontline staff's interviews to illustrate these findings.

Managers' Feelings about Change

Managers stated that it had been difficult to establish coherent teams when different working practices existed across disciplines and sectors, individuals could have different employers with competing priorities and agendas, and teams were often physically separate.

> The XXX structure is a top-down structure; that means that [xx] as director, he is employed jointly by us [County Government] and the PCT, and below him, he has got joint health and social care service managers, and health and social care team managers; half of whom are employed by health and half by us. In other words, its 50 : 50 funded. … so the management is joint but the teams they manage are still functioning separately. [Social/Home Care Services Manager]

Individual managers were often frustrated by not knowing the people in the new organization.

> I worked for two and a half years in the PCT and I could just walk back in their office, I could close their door and walk to the person's desk and talk to them. Now I have got to ask two or three or four people to find out who it is, and when I find them, they won't know what I am talking about. [Social/Home Care Services Manager]

Fear over potential job losses due to restructuring was seen as further destabilizing the organization and coloring individuals' reactions to changes in governance.

> A lot of people are in doubt about their jobs and my experience has been that there's probably more disruption for us. [Director Community Services & Service Manager Social/Home Care, joint post between health and social/community care]

Managers felt that they were under threat of losing their jobs more than frontline staff.

> At individual clinician level, it's unlikely that there'll be changes. What we are dealing with at the moment is the fact that we had five PCTs and five management structures… It only really has an impact on people who are managing teams or had lead roles that don't make sense now we're one organization. [Human Resources Director]

Frontline Professionals' Feelings about Change

Frontline staff described the new teams as still being divided physically (thus mirroring the managers' feelings and experiences). These new structural arrangements left them feeling confused rather than fearful (like the managers) of losing their jobs.

> The main issue I do have at the moment is that we have a Director that doesn't listen … he's employed jointly by health and social care, but he's doing what was traditionally two roles and the expectation of the county council is that he's an Area Director like all the others but in reality his job is so much more complex than the others, so he's got to flit between the two and he doesn't have the time really to spend in each area. [Social/Home Care Services Team Manager]

Clinical staff described feeling confused over what was expected of them and not knowing what was being planned for the future.

> Nobody tells us about them and the PCT hasn't made it its job to engage with clinicians. [General Practitioner]

> The interpretation of policy differs depending on [the] professional background of those in top management. It can be a struggle to work with this. [Social Worker]

There was a sense of an invisible hierarchy sending orders down and creating confusion in the organization. Clinical staff struggled to make sense of the policy directives and understand what it would mean for them, with some differences noted between health and social care.

> [It] was better in when worked in social services…in health, I don't think we had time to look at policies in detail. We might be told 'there is a change to a process' because of a policy but we wouldn't link it…we wouldn't really be made aware of the whole thing. [Specialist Nurse]

Trying to make sense of policy was further exacerbated by the impact of organizational change on structures, which was seen as poorly aligned in terms of providing coordinated care for patients.

> It's incredibly confusing, it's… We struggle with it, there's not a single member here that doesn't struggle with how the services are set up and how to access them and how Joe Public manages sometimes, the vulnerable Joe Public. [Social Worker Mental Health]

There were many examples in the data of staff feeling stressed due to increasing workloads, feeling bombarded by initiatives, and being near to giving up.

> I don't know if it was the end of last year or the beginning of this year, where I felt if I heard one more new initiative, I thought I was just going to give up because I just couldn't cope with any more. [Mental Health Community Nurse]

Another community nurse felt "rushed":

> "I'm always rushed and going onto the next job and may be patients actually… notice…you know, that little special 10/15 minutes that you would sit with them, sort out the problem." [Community Nurse]

A social worker described the changes as having made time for reflection disappear.

> Because you need time to think and reflect and make sure that everything is clearly explained. Which does take time and I think that's the problem, you don't have time anymore. [Social Worker]

Others described confusion due to rapid changes, half-implemented changes, and multiple pathways.

> I find some of these care packages very fragmented. And it's, to maybe get a social care package it's very difficult for me to initiate that or instigate that. It has to go through a whole referral process which is laborious and tedious and repetitive, so that makes that very difficult. And also accessing even within our own trust the

> therapy services, to enable people to stay at home. I find the system very confusing and if I find the system confusing, I am sure most other people do as well because I have worked here for a long time. [Community Nurse Physical Illness]

This quote is a good example of the professional liking the policy but finding the processes to implement it burdensome. There were other practitioners who reported that they felt experiences for some patients were improved:

> we would aim to be spending 45–60 minutes with patients on a visit, unless it's giving medicines or unless they are saying, "I don't want you here for an hour, it's my evening, thanks very much." I think patients get much more time with us than they would if they were on the ward for instance. [Community Psychiatric Nurse]

> …so I mean, certainly the actual factual feedback we have from the patients is that they prefer the service as it now. They much prefer having treatment, being treated in their own homes as opposed to hospital care, so I think it's had a massive impact. [Community Nurse Mental Illness]

Incentives and Change

The frontline staff appeared not to recognize positive effects new incentives had on changing their practice. Instead, they referred to intrinsic motivations such as pleasure derived from seeing an improvement in patient outcome or the feeling of having done a good job and extrinsic motivations such as working in a supportive team. The following quote is typical:

> My satisfaction comes from when it's done well and when it's done well it's done very well, as I said ……well. [GP]

Some of those interviewed mentioned incentives such as training and education. One occupational therapist felt that potential litigation was an incentive, "I don't know that there's any kind of external incentive. I suppose the thought of, um, you know, a misconduct suit or something like that."

Disincentives were also described:

> R: And what's dissatisfying for you?

> Oh, paper work and I suppose there's also the frustration of when, when you want to help someone and actually there's nothing you can do, that you cannot fix their lives or you cannot fix their health problems. [C18 Community Nurse Physical Care]

For some staff, the increased workload meant that they felt under pressure and wanted to leave.

> Well, ultimately, if people get change fatigue and, what concerns me, and I'm seeing this [here] at the moment that people are just, you know, throwing in the towel, had enough. [Senior Community Nurse Physical Care]

Forming New Interprofessional Teams

Lack of continuity of care for patients may have contributed further to practitioners' personal frustrations and lack of satisfaction.

> However, I do think maybe lots of different people going and doing sort of the same things, you know. I don't know that it's always necessary to have somebody to look at a frame and then somebody else to look at a bed and somebody else to look at a… you know, and I think that can be very confusing. [Community Nurse Physical Illness]

Efforts were made to address this duplication, for example, by coordinating visits from different services. Patients and clients themselves developed strategies to negotiate the thicket of disparate and uncoordinated services.

Managers and frontline staff were able to suggest ways in which new teams might be encouraged to form:

> If you want people to work together, get them to talk to each other. It's probably saying really things will be better—putting names to faces and all of that kind of self-system stuff works very well. [Occupational Therapist Physical Care]

Encouraging team working was described in terms of supporting staff to adapt to the changes in the delivery of care. There was evidence that at a team level, mental health team managers were using supervision, which is an established way to acknowledge painful emotions in practice and process defenses (Selby, 1999; Butterworth et al. 2008). Supervision was described as a regular mental health team activity:

> Then we have, um, an opportunity to meet as a team on a weekly basis to discuss our concerns with individual clients, everybody has individual clinical supervision and there is a group of seniors that meet regularly as well. [Senior Mental Health Nurse]

For managers of teams working with people with physical conditions, references to supervision and support were scarce and focused more on performance (reskimming):

> We're actually going down… re-skimming these individuals and helping them to work through some of the… through supervision, clinical supervision, peer supervision, really sort of sitting down and finding out what is it, what is the cause. [Social Care Services Team Manager]

DISCUSSION

The responses from managers and frontline professionals to new governance arrangements and incentives following the recent restructuring of service delivery in primary care in England suggest that integrating new interprofessional teams to work effectively is a slow process. Staff are uncertain about their new roles and responsibilities, feel overworked, and are concerned that their effectiveness has been compromised. This is congruent with findings by North American (Rusaw 2009) and other U.K. authors (Glasby and Peck 2006; Goddard and Mannion 2006; Staniland 2009; Peckham and Wallace 2010).

Most professionals in this study broadly agreed with the aims of care closer to home and patient choice but experienced change as imposed top down with little scope for them to influence it. Some experienced this as personal distress and others as frustration at not being part of a well-thought-out system. Glasby and Peck (2006) argue that governance can be symbolic, which our data do not support—as the managers appeared equally conflicted. Rather we suggest that this level of symbolic or meaningful leadership had yet to emerge (Spyridonidis and Calnan 2010).

Understanding governance of organizations undergoing change raises major challenges (Dowling, Sheaff, and Pickard 2008; Delva, Jamieson, and Lemieux 2008). As Ross et al. (2011, 289) argue, governance is not "a linear or discrete concept but rather one that displays connections between organizational facets and people relationships that make organizations work." It is individuals' perceptions, and how their understandings and perspectives shape their behaviors, which expand our understanding of complex change in large organizations such as the NHS (Staniland 2009; Spyridonidis and Calnan 2010).

This study contributes to the literature on governance by unpacking the intermediate processes between the operationalization of national governance and incentives policies aimed at reconfiguring service delivery, and the experiences of individuals at the team level.

Although there were shared feelings of frustration and of not being in control, there were some differences between the experiences described by managers and frontline staff. Not surprisingly, managers tended to focus on the strategic restructuring of services and financial accountability (Spyridonidis and Calnan 2010; Smith et al. 2012), whereas clinical staff tried their best to meet the expectations of service users by continuing and getting the job done despite constant change.

Multiple perspectives and lack of a coherent narrative on the restructuring emerged from the manager and clinical staff interviews. These multiple narratives provide further evidence of existing splits between health and social care in the British system (Allan et al. 2005; Hall 2005; Goddard and Mannion 2006; Baxter and Brumfitt 2008; Dowling, Sheaff, and Pickard 2008).

For both groups, the findings suggest a misalignment between the policy language and the narrative of change as professionals struggled to make sense of, interpret, and apply policy directives in the delivery of care at both management and frontline levels, while demonstrating their commitment to "do a good job." This illustrates the dangers of oversimplifying definitions of incentives, as in practice they play out in complex ways, influenced by context, professional, and personal factors (Peckham and Wallace 2010).

Frontline staff experiences of feeling bombarded and overloaded led some to want to give up and leave altogether; however, for others, this was mitigated by the intrinsic incentive to do a good job, in spite of these pressures.

Choices to remain or exit organizations undergoing change have been studied from the perspective of governance in the Canadian health care system (Birch and Petrie 2009). They used Hirschman's 1970 analysis to show how exit, loyalty, and voice are strategies to adapt to changes. Our findings show that some frontline and management staff voiced their views to energize their staff to survive and prosper through, for example, supervision in mental health teams. Showing loyalty, and seeing processes through in the belief that good intentions and ordered processes would deliver positive outcomes was encouraged in some cases, for example, the community nurses who identified they had gained more patient contact time. Loyalty and voice are therefore strategies used by NHS staff in these case study sites to adapt to system change. However, in the U.K. context, options around exit may be more

constrained given the fewer labor options in the British health care system in 2012 (Sprinks 2012). Exit was a choice referred to by some frontline staff without explanation of future employment options. However, imposed exit or redundancy as referred to by managers was not one which has been commented on by Birch and Petrie (2009) or others (Rusbult et al. 1988; Hoffman 2006), as it is not generally related to job dissatisfaction.

Our findings contribute to the literature on the role that emotions play in team work (Smith, Pearson and Ross 2009; Cameron 2011). It is noteworthy that (a) *both* managers and frontline staff felt themselves to be under pressure, although in different ways, and (b) managers and frontline staff expressed concerns about organizational restructuring. In particular, there was concern about the lack of physical proximity of some new teams, which reduced opportunity for team processes to develop (Delva, Jamieson, and Lemieux 2008). Although some of the literature on teams emphasizes the contribution of organizational psychology (West and Field 1995a,b), in general, the role of emotions is underplayed (Franks, Watts, and Fabricius 1994).

During the introduction of new community services, staff and managers in new and preexisting teams had to contend with emotions raised both by taking on new roles in patient care and by forming new partnerships and teams across disciplines, which historically have not worked together (Allan et al. 2005; Hall 2005; Baxter and Brumfitt 2008). However, the emotions expressed in the interviews were not apparently shared between the professional groups, and there seemed little insight into how emotions were being handled by others, although there was evidence of some support for frontline staff within existing teams, if not new teams.

Our findings show that integrating new interprofessional teams is a slow process especially if structures in place do not acknowledge the painful feelings involved in change and do not support staff during uncertainty. Support in the form of supervision appeared to be available for mental health teams, through a reflective, group and/or individual approach, but this is a costly in time in a system which is already under pressure. For teams working with people with physical long-term conditions, support was described in terms of performance management. Perhaps this is not surprising given Butterworth's et al. review of the clinical supervision literature, which suggests that nurses continue to receive an inadequate amount of supervision (2008). They suggest that as *unfortunately*[4] current research hints at the benefits of supervision on patient outcome, but does not make the link explicitly, this makes clinical supervision less of an organizational

priority for physical care teams, and it is often not evident within governance structures. Given that clinical matters make up less than 14 percent of agenda items at NHS Trust Board level (Burdett Trust 2006), it is not surprising if there is a lack of attention given by some trusts and some managers to supervision and support. The practitioners also emphasize how chaotic and dysfunctional working in the community can feel with discontinuities, half-implemented policies, and rapidly implemented change. The need for emotional support for practitioners might be lessened if the systems they are working in were better aligned.

Finally, can these findings be useful in other health care contexts? Worldwide, there is an increasing chronic illness burden, a desire to reduce health care costs, and an increasing aging population (Daar et al. 2007; Birch and Petrie 2009; Centers for Disease Control and Prevention 2009; Shortell, Gillies, and Wu 2010). Although health care systems in the United States, Australia, and Canada, for example, are funded differently from the United Kingdom, they all face these pressures (American College of Physicians: Health and Public Policy Committee 2008; Birch and Petrie 2009; Peckham and Wallace 2010; Shortell, Gillies, and Wu 2010; Sweet 2010). Similar attempts have been made to reorganize the health care system in both the U.S. and the U.K. primary care context, for example, to change commissioning patterns and payments and create less fragmented systems which reward the achievement of health outcomes rather than fee for service (Ferlie and Shortell 2001) and to redesign community teams (Jackson et al. 2012). Therefore, these findings are pertinent for other primary health care systems even if structures differ. While the concepts of governance are centrally located, the operationalization of them is locally determined, which is similar to more devolved systems of health care (Ferlie and Shortell 2001). It could also be argued that the U.K. system is becoming increasingly like the U.S. system as provision becomes more marketized (Davies et al. 2005), and integrated community care policies such as the Medical Home are pursued in the United States (Jackson et al. 2012).

LIMITATIONS

The limitations of this study are that the data were collected at one time point (2006–2008) and therefore views expressed could reflect a particular period of turbulence or change within the British National Health Service, making its cross-sectional nature less valid (Plamping 1998). We addressed this issue as far as possible by focusing the interviews on the current reorga-

nization. However, research shows that the NHS undergoes continual change (Appleby 2012; Smith et al. 2012) and that turbulence has if anything increased since 2008 (NHS Staff Survey 2011; Appleby 2012). It remains unclear whether staff believe these changes to governance and incentives are qualitatively different from previous changes, and of course interviewees did not foresee the current austerity policies of the Coalition government. Our study adds to the literature on governance by providing a detailed exploration of how professionals experience changes to complex health care systems at the relationship and emotional level. We have not contributed to an analysis here of the dynamic of centralization/decentralization or that of the market and new performance management. This is published elsewhere (Smith et al. 2012).

Lastly, the interviews were not complemented by observational or other sources of data. However, we believe that rich and deep cross-case analysis reassures the reader that these views do not represent just one organizational context but may be transferable to other international contexts.

Conclusions

We suggest that the role of emotions and relationships within new governance structures lacks visibility in current narratives on governance and incentives. Policy makers need to take seriously the professional perspective in managing change, within the context of diversity, variously configured teams, and individual occupational positioning. In other words, they need to prepare and give voice to service users, carers, and professionals when implementing system change.

We agree with Davies et al. (2005) that organizational change encompasses more than formal, legal, and reporting structures and that multiple levels of power operate in complex organizational and professional relationships. Organizational change increases pressure and dissatisfaction. Our findings suggest that the conceptual thinking around change locally should take more account of the emotional domain. In particular, implementation of policy change needs not only to be well designed but to take account of the heterogeneity of professional identities and interests in primary care and the important contribution that support, including clinical supervision, leadership, and encouragement, can make to professionals' working lives.

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NOTES

1. We do not offer a patient perspective to these organizational changes; this is reported elsewhere (Ross et al. 2009).
2. Each team consisted of more than 8–10 staff.
3. In England, a community matron is a skilled community nurse who manages patients with complex, long-term conditions.
4. Authors' italics.

REFERENCES

Allan, H. T., L. Clawson, K. Bryan, and P. A. Smith. 2005. "It's Stepping out of the Box a Bit and Surprising Ourselves: Developing a Learning Culture in Primary Care." *Journal of Interprofessional Care* 19 (5): 452–64.

American College of Physicians: Health and Public Policy Committee. 2008. "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries." *Annals of Internal Medicine* 148 (1): 55–75.

Appleby, J. 2012. *Public Satisfaction with the NHS and Its Services. Headlines from the British Social Attitudes Survey*. London: The King's Fund.

Baxter, S. K., and S. M. Brumfitt. 2008. "Professional Differences in Interprofessional Working." *Journal Interprofessional Care* 22 (3): 239–51.

Belanger, E., and C. Rodriguez. 2008. "More Than the Sum of Its Parts? A Qualitative Research Synthesis on Multi-Disciplinary Primary Care Teams." *Journal of Interprofessional Care* 22 (6): 587–97.

Birch, L., and F. Petrie. 2009. *Exit, Voice and Loyalty and the Future of Healthcare in Canada: Insights from Public Opinion Research*. Centre for the Analysis of Public Policy, Department of Political Science, Laval University: Quebec City, Canada.

Brown, B. J., L. Lewis, K. Ellis, S. Thomas, R. Freeman, and M. J. Kasperski. 2011. "Conflict on Interprofessional Primary Health Care Teams – Can It Be Resolved?" *Journal of Interprofessional Care* 25 (1): 4–10.

Burdett Trust. 2006. *Who Cares, Wins, Leadership and the Business of Caring.* London: The Burdett Trust.

Butterworth, R. T., L. Bell, C. Jackson, and M. Pajnkihar. 2008. "Wicked Spell or Magic Bullet? A Review of the Clinical Supervision Literature 2001–2007." *Nurse Education Today* 28: 264–72.

Byng, R., I. Norman, and S. Redfern. 2005. "Using Realistic Evaluation to Evaluate a Practice-Level Intervention to Improve Primary Health Care for Patients with Long-Term Mental Illness." *Evaluation* 11 (1): 69–93.

Cameron, A. 2011. "Impermeable Boundaries? Development in Professional Inter-Professional Practice." *Journal of Interprofessional Care* 25 (1): 53–8.

Cardona, F.. 1994. Facing an Uncertain Future. In *The Unconscious at Work: Individual and Organizational Stress in the Human Services*, edited by A. Obholzer and V. Zagier Roberts, pp. 139–46. London: Routledge.

Centers for Disease Control and Prevention. 2009. *Chronic Diseases: The Power to Prevent, the Call to Control, At-A-Glance 2009.* Atlanta, GA: U.S. Department of Health and Human Services.

Daar, A. S., P. A. Singer, D. L. Persad, S. K. Pramming, D. R. Matthews, and R. Beaglehole. 2007. "Grand Challenges in Chronic non-Communicable Diseases." *Nature* 450: 494–6.

Davies, C., P. Anand, L. Artigas, J. Holloway, K. McConway, J. Newman, J. Storey, and G. Thompson. 2005. Links between Governance, Incentives and Outcomes: A Review of the Literature. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). [July 5, 2011]. Available at www.sdo.nihr.ac.uk/files/project/SDO_ES_08-1318-066_V01.pdf.

Delva, D., M. Jamieson, and M. Lemieux. 2008. "Team Effectiveness in Academic Primary Health Care Teams." *Journal of Interprofessional Care* 22 (6): 598–611.

Dowling, B., R. Sheaff, and S. Pickard. 2008. "Governance Structures and Accountability in Primary Care." *Public Money and Management* 28 (4): 215–22.

Ferlie, E., and S. M. Shortell. 2001. "Improving the Quality of Healthcare in the United Kingdom and the United States: A Framework for Change." *The Millbank Quarterley* 79 (2): 281–315.

Franks, V., M. Watts, and J. Fabricius. 1994. "Interpersonal Learning in Groups: An Investigation." *Journal of Advanced Nursing* 20: 1162–9.

Furne, A., E. Rink, and F. Ross. 2001. "The Integrated Nursing Team in Primary Care: Views and Experience of Participants Exploring Ownership, Objectives and a Team Orientation." *Primary Health Care Research and Development* 2: 187–95.

Glasby, J., andH. Dickinson. 2008. *Partnership Working in Health and Social Care.* Bristol: Policy Press/Community Care, p. 17 and p. 90.

Glasby, J., G. Martin, and E. Regen. 2008. "Older People and the Relationship between Hospital Services and Intermediate Care: Results from a National Evaluation." *Journal of Interprofessional Care* 22 (6): 639–49.

Glasby, J., and E. Peck. 2006. "We Have to Stop Meeting Like This: The Governance of Inter-Agency Partnerships. A Discussion Article." Care Services Improvement Partnership Integrated Care Network [accessed on July 5, 2011]. Available at www.icn.csip.org.uk.

Goddard, M., and R. Mannion. 2006. "Decentralising the NHS:The Rhetoric, Reality and Paradox." *Journal of Health Organisation and Management* 20 (1): 67–83.

Hall, P. 2005. "Interprofessional Teamwork: Professional Cultures as Barriers." *Journal of Interprofessional Care* 19 (5): 188–96.

Her Majesty's Government. 2007. Putting People First. A Shared Vision and Commitment to the Transformation of Adult Social Care [accessed on March 3, 2011]. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081119.pdf.

Hoffman, E. A. 2006. "Exit and Voice: Organisational Loyalty and Dispute Resolution Strategies." *Social Forces* 84 (4): 2313–30.

Jackson, G. L., B. J. Powers, R. Chatterjee, J. P. Bettger, A. R. Kemper, V. Hasselblad, R. J. Dolor, J. Irvinve, B. L. Heidenfelder, A. S. Kendrick, R. Grray, and J. W. Williams Jr, 2012. The Patient-Centred Medical Home: A Systematic Review. *Annals of Internal Medicine* 27: 374–89.

Mackintosh, M. 1992. "Partnership: Issues of Policy and Negotiation." *Local Economy* 7 (3): 210–24.

National Health Services Staff Survey. 2012 [accessed June 6, 2013]. Available at http://www.nhsstaffsurveys.com/cms/.

Obholzer, A. 1994. Managing Anxieties in Public Sector Organisations. In *The Unconscious at Work: Individual and Organizational Stress in the Human Services*, edited by A. Obholzer and V. Zagier Roberts, pp. 169–78. London: Routledge.

Obholzer, A., and V. Zagier Roberts (Eds.). 1994. *The Unconscious at Work: Individual and Organizational Stress in the Human Services.* London: Routledge.

Pawson, R., and N. Tilley. 1997. *Realistic Evaluation.* London: Sage Publications.

———. 2004. Realist Evaluation. Article funded by British Cabinet Office [accessed on June 6, 2013]. Available at http://www.communitymatters.com.au/RE_chapter.pdf.

Peckham, S., and A. Wallace. 2010. "Pay for Performance Schemes in Primary Care: What Have we Learnt?" *Quality in Primary Care* 18: 111–6.

Pescosolido, A. T. 2002. "Emergent Leaders as Managers of Group Emotion." *The Leadership Quarterly* 13: 583–99.

Plamping, D.. 1998. Change and Resistance to Change on the NHS. *British Medical Journal* 317: 69.

Poulton, B., and M. West. 1999. "The Determinants of Effectiveness in Primary Health Care Teams." *Journal of Interprofessional Care* 13 (1): 7–18.

Ross, F., R. Byng, J. Manthorpe, S. Brearley, S. Redfern, P. Smith, S. Christian, M. M. Mackintosh, J. A. Larsen, and C. Davies. 2009. The Professional Experience of Governance and Incentives: Meeting the Needs of People with Complex Conditions in Primary Care [accessed on February 11, 2011]. Available at http://www.sdo.nihr.ac.uk/files/project/128-final-report.pdf.

Ross, F., S. Redfern, R. Harris, and S. Christian. 2011. "The Impact of Nursing Innovations in the Context of Governance and Incentives." *Journal of Research in Nursing* 16 (3): 274–94.

Rusaw, C. 2009. "Professionalism under the "Performance-Based Pay" Reform: A Critical Assessment and Alternative Development Model." *Public Personnel Management* 38 (4): 35–54.

Rusbult, C. E., D. Farrell, G. Rogers, and A. G. Mainous 111. 1988. "Impact of Exchange Variables on Exit, Loyalty and Neglect: An Integrative Model of Responses to Declining Job Satisfaction." *Academy of Management Journal* 31 (3): 599–627.

Selby, J. 2000. "Reflective Practice and Action Research in Balint Seminars." In *Caring for Sexuality in Health and Illness*, edited by D. Wells. London: Churchill Livingstone.

Shortell, M. S., R. Gillies, and F. Wu. 2010. "United States Innovations in Health Care Delivery." *Public Health Reviews* 32: 190–212.

Smith, P., and K. Bryan. 2005. "Participatory Evaluation: Navigating the Emotions of Partnerships." *Journal of Social Work Practice* 19 (2): 189–202.

Smith, P., and H. Cowie. 2010. "Perspectives on Emotional Labour and Bullying: Reviewing the Role of Emotions in Nursing and Health Care." *International Journal of Work Organisation and Emotion* 3 (3): 227–36.

Smith, P., M. M. Macintosh, F. Ross, J. Clayton, L. Price, S. Christian, R. Byng, and H. Allan. 2012. "Financial and Clinical Risk in Health Care Reform: A View from Below." *Journal of Health Services Research and Policy* 17 (Suppl 2): 11–7.

Smith, P., P. Pearson, and F. Ross. 2009. "Emotions at Work: What is the Link to Patient Safety? Implications for Nurse Managers in the NHS." *Nursing Management* 17 (2): 230–37.

Sprinks, J. 2012. Hundreds of NHS Staff Apply for Early Exit Scheme. Nursing Standard on-line [accessed June 6, 2013]. Available at http://nursingstandard.rc.publishing.co.uk/news-and-opinion/news/hundreds -of-stressed-staff-apply-for-early-exit-scheme.

Spyridonidis, D., and M. Calnan. 2010. "Implementing Clinical Governance Policy: NICE." *British Journal Healthcare Management* 16 (8): 394–401.

Staniland, K. 2009. "A Sociological Ethnographic Study of Clinical Governance Implementation in One NHS Hospital Trust." *Clinical Governance: An International Journal* 14 (4): 271–80.

Stokes, J. 1994. "Institutional Chaos and Personal Stress." In *The Unconscious at Work: Individual and Organizational Stress in the Human Services*, edited by A. Obholzer and V. Zagier Roberts, pp. 121–8. London: Routledge.

Sweet, M. 2010. "Health Reform: A Time of Opportunity and Challenge." *Australian Nursing Journal* 18 (2): 28–31.

Taylor, D. 2006. "What Immortal Hand or Eye Has Framed Thy Fearful Symmetry?" Article presented at Governed States of Mind: Thinking Psychoanalytically. UK: St. Hugh's College Oxford, March 24–25, 2006.

West, M. 2004. *Effective Teamwork: Practical Lessons from Organisational Research.* Oxford, UK: Blackwell.

West, M., F. Brodbeck, and A. Richter. 2004. "Does the "Romance of Teams" Exist? The Effectiveness of Teams in Experimental and Field Settings." *Journal of Occupational and Organisational Psychology* 77: 467–73.

West, M., and R. Field. 1995a. ""Teamwork in Primary Health Care1. Perspectives from Organisational Psychology." *Journal of Interprofessional Care* 9 (2): 117–22.

———. 1995b. "Teamwork in Primary Health Care 2. Perspectives from Organisational Psychology." *Journal of Interprofessional Care* 9 (2): 123–30.

Zwarenstein, M., and S. Reeves. 2006. "Knowledge Translation and Interprofessional Collaboration: Where the Rubber of Evidence-Based Care Hits the Road of Teamwork." *Journal of Continuing Education in the Health Professions* 26 (1): 46–54.

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.